

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08444

170C

Reg. Dist. No. 202

1. PLACE OF DEATH:

County ChesterCity or town Chester town
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred:

Med + PA HospHow long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty ChesterCity or town Chester town
(If outside city or town limits, write RURAL and give nearest town)Street No. 11

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

HILL 1949 Cahall

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Maudy Cahall6. (c) If alive, give age 35 years

7. Birth date of

deceased (mo., day, yr.)

Aug 19, 1909

8. AGE:

Years 39Months 6Days 4

If less than one day

hrs. min.

9. Birthplace

Baltimore, Md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farmer

12. Name

Wesley Cahall

13. Birthplace

Carroll Co Md

14. Maiden name

Edith Bradley

15. Birthplace

Carroll Co Md

16. Informant

Chas F. town

Address

Buhal

17. (Burial, cremation, or removal, which?)

BurialDate thereof Aug 27, 1948

(month) (day) (year)

Cemetery or crematory

Templeville

Location

Templeville, Md

18. Funeral director

Edward J. Hall

Address

Wallington MdDate reg'd by registrar Aug. 25, 48Registrar Dora S. BarnesAddress Chester town MdDate signed Aug 28, 48

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 23, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him

alive on Aug 22, 1948

Immediate cause of death

Basal Fracture of

skull

Due to

Accident

Other conditions

Fracture of

skull

Due to

Accident

Other conditions

Fracture of

skull

Due to

Accident

Other conditions

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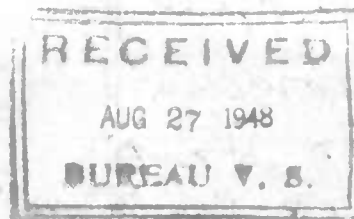
Due to

Accident

Other conditions

Fracture of

skull



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age shown on:

FILE No. G 117 SEP 15 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 204

1. PLACE OF DEATH:

County Kent
City or town Rural Fairlee
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Kent
City or town Rural Fairlee
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Moses Cann

3.(b) Social Security Number

4. Sex male 5. Color or race colored 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Sarah Cann
living 6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Unknown 1882
8. AGE: Years 66 Months 00 Days ? If less than one day hrs. min.

9. Birthplace Kent Co., Maryland
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
12. Name Clem Cann
13. Birthplace Maryland
14. Maiden name Clara - (Unknown)
15. Birthplace SANDY BOTTOM, KENT CO., MD.

16. Informant Mrs. Annie Woods
Address Baltimore, Md.
17. Burial Date thereof Sept. 5 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Sandy Bottom (Col.) Cem.
Location Kent County, Maryland
18. Funeral director J. Willis Wells
Address Chestertown, Maryland
19. Sept 13 19 48 J.W. Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August - 31 19 48 at 5 P M
21. CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 - 1948 to Aug 30 19 48
and that I last saw him alive on Aug 30 19 48
Immediate cause of death

Cardiac Spasmodic Disease DURATION 7 years
Due to
Due to
Other conditions Coronary Thrombosis 3 days
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work
23. SIGNATURE Frank W. Smith M. D. or other
Address Chestertown Date signed Sept 7/48

RECEIVED

SEP 6 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent

City or town Rural Kennedyville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Kent

City or town Rural Kennedyville
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Carrie C. Cornelius

3. (b) Social Security Number

4. Sex

Fem.

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Clarence Cornelius
(deceased)

7. Birth date of deceased (mo., day, yr.)

Sept 9 - 1875

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

72

11

11

hrs.

min.

9. Birthplace

Green Anne Co. Ind.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Thomas Mc Kenney

13. Birthplace

Green Anne Co. Ind.

14. Maiden name

Sarah Walls

15. Birthplace

Green Anne Co. Ind.

16. Informant

Mrs. Mary Guinness

Address

Kennedyville

17.

(Burial, cremation, or removal, which?)

Date thereof

Aug. 23. 48
(month) (day) (year)

Cemetery or crematory

Still Pond

Location

Still Pond Ind.

18. Funeral director

Edgar L. Lane

Address

Church Hill Ind.

19.

(Date rec'd by registrar)

Aug. 23. 48

Claw S. Barnes

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1948, at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 8, 1948, to August 20, 1948, and that I last saw her alive on August 20, 1948.

Immediate cause of death

Bronchopneumonia

DURATION

2 days

Due to

Due to

Other conditions

Arterio Sclerotic

Kidney & heart disease
(Include pregnancy within 3 months of death)

2 years

Major findings of operations

None done

Autopsy results

None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thomas H. Paprocki MD

M. D. or other

Address

Edgar L. Lane

Date signed 8-23-48

RECEIVED

AUG 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08447

Reg. Dist. No. 202

1. PLACE OF DEATH:

Kent
County.....
City or town.....
Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
life
Hospital, institution, or street address where death occurred:
High St.
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland..... County..... Kent
City or town..... Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME

Margaret Mae Gallaway

3.(b) Social Security Number

4. Sex..... female
5. Color or race..... white
6.(a) Single, married, widowed, or divorced..... widowed

6.(b) Name of husband or wife..... Joshua Gallaway
6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... May 26, 1885

8. AGE: Years..... 63 Months..... 2 Days..... 21 If less than one day..... hrs. min.

9. Birthplace..... Kent County Maryland
(Town, county, and state)

10. Usual occupation..... housewife - Boarders

11. Industry or business.....

12. Name..... Daniel Pennington

13. Birthplace..... Kent Co. Maryland

14. Maiden name..... Emma Hoffman

15. Birthplace..... Kent Co. Maryland

16. Informant..... Mrs. Emma Hickman

Address..... Chestertown, Md.

17. Burial..... Date thereof..... August 19, 1948

(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory..... Chester Cemetery

Location..... Chestertown, Maryland

18. Funeral director..... J. Willis Wells

Address..... Chestertown, Maryland

19. Aug. 19, 1948..... Clara S. Barnes

(Date read by registrar)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 17, 1948, at 620 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1948, to Aug. 17, 1948, and that I last saw her alive on 8-17, 1948.

Immediate cause of death.....

Carcinoma of the uterus

Due to..... Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Co of uterus

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Albert A. Burgard

Address..... Rock Hall, Md. Date signed..... 8/18/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Martha S. Hart

7. Birth date of deceased (mo., day, yr.)

Feb 21, 1894

6. (c) If alive, give age..... years

49

8. AGE:

Years

53

Months

6

Days

26

If less than one day

hrs.

min.

Middlesex Co. Va

(Town, county, and state)

9. Birthplace

Bank Beach

10. Usual occupation

General Workman Bank

11. Industry or business

Bony Hart

12. Name

Virginia

13. Birthplace

Martha Thomas

14. Maiden name

Virginia

15. Birthplace

Martha S. Hart

16. Informant

6308 Orleans St. Baltimore

Address

Burial

17. (Burial, cremation, or removal. Which?)

Date thereof Aug 18/48

(month) (day) (year)

Oak Lawn

Cemetery or crematory

Baltimore Co. Md

Location

William Funeral Home

18. Funeral director

2008 Orleans St

Address

8/12

19. (Date rec'd by registrar)

48

19. 48

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. CERTIFY that death occurred on the date above stated; that I attended deceased from.....

and that I have signed this certificate as true and correct.

Immediate cause of death.....

Duration.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

Signature.....

Date signed.....

M. D. or other

Date signed.....

Date signed.....

Date signed.....

Date signed.....

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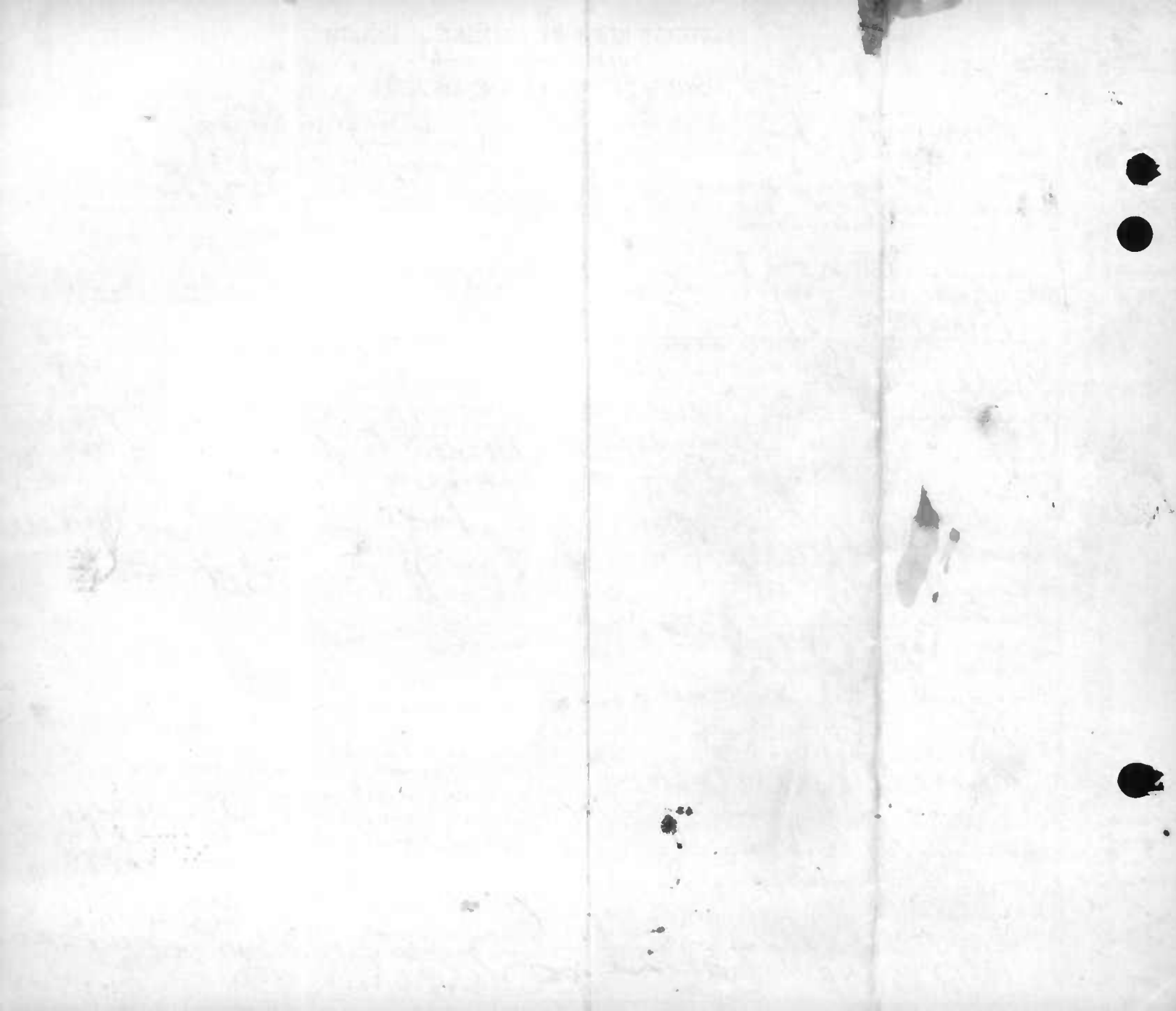
Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 • 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. correct age is especially important. Physicians: please write the causes of death clearly and legibly

08446



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08449

Reg. Dist. No. 203

1. PLACE OF DEATH:

County Kent
 City or town Rock Hall Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred: Beggs Dr
 How long in hospital or institution? life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Rock Hall Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Beggs Dr
 (If rural give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Frances Lou Henry

3. (b) Social Security Number

4. Sex female 5. Color or race col. 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Geo. Th. Henry
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) August 13 1873
 8. AGE: Years 75 Months - Days - If less than one day..... hrs. min.

9. Birthplace Rock Hall, Md.
 (Town, county, and state)
 10. Usual occupation housewife
 11. Industry or business -
 12. Name Hamilton Banks
 13. Birthplace Kent Co, Md.
 14. Maiden name Mary E. Burkhard
 15. Birthplace Kent Co, Md.
 16. Informant Hannigan Rochester
 Address Rock Hall, Md.

17. Burial Date thereof Aug 17 1948
 (Burial, cremation, or removal Which?) (month) (day) (year)
 Cemetery or crematorium Shraptown
 Location Rock Hall Md
 18. Funeral director Asbury Henry
 Address Chestertown Md
 19. Aug 16 - 1948 S Elwood Binger
 (Date rec'd by registrar) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1948 at 3:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 1947 to 8/13 1948
 and that I last saw him alive on 8/12 1948
 Immediate cause of death..... DURATION.....
Chronic Endocarditis
decompensation
 Due to.....
Carcinoma of rectum
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations..... Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE Robert G. Burgard M. D. other
 Address Rock Hall, Md Date signed 8/14/48

RECEIVED

AUG 25 1948

BUREAU F. B. I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County KentCity or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? all life

Hospital, institution, or street address where death occurred:

359 Calvert St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)Street No. 359 Calvert
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Cora Houston

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Col

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Delbert Houston

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

January 2 1878

8. AGE:

Years

Months

Days

If less than one day

7689

hrs.

min.

9. Birthplace Chesapeake Kent Co Maryland
(City, county, and state)

10. Usual occupation

housewife

11. Industry or business

home

FATHER

12. Name

unknown

13. Birthplace

"

MOTHER

14. Maiden name

unknown

15. Birthplace

"16. Informant Mrs Stella WilliamsAddress 359 Calvert St. Chesapeake Md.17. Burial
(Burial, cremation, or removal. Which?)Date thereof Aug 13 1948
(month) (day) (year)

Cemetery or crematory

Chesapeake Peninsula

Location

Peninsula - near Chesapeake Md

18. Funeral director

Morris V. Williams

Address

Chesapeake Maryland19. Aug 13 1948
(Date registered by Registrar)Clara S. Barnes
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1948 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-15 1948, to 8-11 1948and that I last saw him alive on 8-11 1948

Immediate cause of death

Congestive heart failure

DURATION

6 months

Due to

auricular fibrillation caused by coronary atherosclerosisseveral years

Due to

Other conditions

Had a fall & injured right hip (no fracture)
(Include pregnancy within 3 months of death)1 week

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. D. IV Jan

M. D. on

Address

Chesapeake MdDate signed 8-12-48

RECEIVED

AUG 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Maryland Dist
 City or town Chesapeake
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all up
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Chesapeake
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Ella Massey

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb 8, 1871

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

77614

hrs.

min.

9. Birthplace

Georgetown, Kent Co, Md
 Town, county, and state

10. Usual occupation

Home

11. Industry or business

12. Name Chas. H. Massey

13. Birthplace

Kent Co, Md

14. Maiden name

Mary Ann Massey

15. Birthplace

Georgetown, Kent Co, Md

16. Informant

Dr. F. M. Brooks

Address

Georgetown, Kent Co, Md

17. Burial

St. Clements

(Burial, cremation, or removal, which?)

Date thereof Aug 24, 1948
 (month) (day) (year)

Cemetery or crematory

St. Clements

Location

Maryland

18. Funeral director

Wm. V. Wilkins

Address

Chesapeake, Maryland

19. Aug 24, 1948

Claire S. Barnes
 (Date registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 19 48 at 3:47 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12, 1948 to Aug 22, 1948
 and that I last saw him alive on Aug 21, 1948Immediate cause of death Massive coronaryobstructionDue to arteriosclerosisDue to chronic kidney disease

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

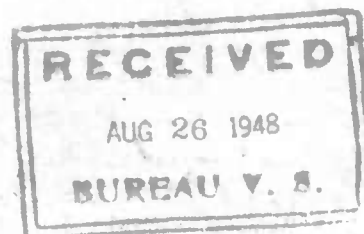
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of _____Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Signature Frank H. HinesAddress Georgetown, Kent Co, MdDate signed Aug 24, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:

County Kent
City or town Rural Millington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Kent
City or town Rural Millington
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Thomas Wallace

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Bessie Jane Wallace

7. Birth date of deceased (mo., day, yr.)

June 20 1866

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

82

hrs.

min.

9. Birthplace

Delaware
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

John T. Wallace

13. Birthplace

Delaware

14. Maiden name

Blawie

15. Birthplace

Delaware

16. Informant

Howard Wallace

Address

Rural Millington Md.

17.

(Burial, cremation, or removal, where)

Date thereof

Aug. 5/1948

Cemetery or crematory

Blackiston Churchyard

Location

Mar. Clayton Del.

18. Funeral director

Edward Fellows

Address

Millington Md.

19.

(Date rec'd by registrar)

19 48Edward Fellows
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 219 48

at

7³⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1319 48

to

Aug 219 48and that I last saw him alive on Aug 1 19 48

Immediate cause of death

Carcinoma of Rectum

DURATION

Due to

Due to

Other conditions

Arteriosclerotic heartdisease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. H. Hamilton

M. D. or other

Address

Millington Md.

Date signed

Aug 4/48

RECEIVED

AUG 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent
 City or town Chesterside Hospital
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 hours
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Chesterside R.R.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Pomona
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

Charles Wood

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 26 / 48 6. (c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days _____ If less than one day 2 1/2 min.

9. Birthplace Kent & Queen Ann Hospital
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Charles Wood13. Birthplace Missouri14. Maiden name Lucy15. Birthplace Chesterside16. Informant Mrs. Chas. WoodAddress Chesterside R.R.17. Burial Date thereof 8-27-48

(Burial, cremation or removal Which?) (month) (day) (year)

Cemetery or crematory Chesterside CemeteryLocation Chesterside18. Funeral director Jessie H. EllettsAddress Chesterside, Md19. Aug 27 1948 Clara S. Barnes

(Date signed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1948 at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____

and that I last saw him _____ alive on _____ 19_____

Immediate cause of death Premature birth DURATIONDue to 1 lb 4 3/4 Infant -HydrocephalusDue to AsphyxiaintrauterineOther conditions None

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Lancel Smith M. D. or otherChesterside Date signed 8/27/48

Address _____ Date signed _____

